WEISMAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-01

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-010

2. STATE: IDAHO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~01-01-2001~~
12-14-2001 (P+I)

5. TYPE OF PLAN MATERIAL *(Check One)*:

DEC 12 2001

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
BIPA of 2000-Section 702

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ ~~150,719.00~~ $127,854.00 (P+I)
b. FFY 2003 $ ~~156,266.00~~ $131,276.00 (P+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 1.b., 2, 3, 4, 5, 6, 7, 8, and 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, pages 1.b, 2, 3, 4, 5, 5.1, 6, 7, 8, and 9

10. SUBJECT OF AMENDMENT:
Revision of the change in reimbursement method for Federally Qualified Health Centers and Rural Health Clinics as required by the Benefit Improvement and Protection Act of 2000, Section 702, ~~which has an effective date of 1/1/01~~. (P+I)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Karl Kurtz

13. TYPED NAME:
KARL B. KURTZ

14. TITLE:
Director

15. DATE SUBMITTED:

16. RETURN TO:

Joseph R. Brunson, Administrator
Idaho Department of Health and Welfare
Divsion of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DEC 12 2001

18. DATE APPROVED: FEB 28 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
DEC 14 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Christine Quebedeaux

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

POSTMARK 12/10 (DATE) Boise (CITY/STATE)

(P+I) changes authorized by the State on 2/19/02. ES

FORM HCFA-179 (07-92)

2. a. v. Patient Education: Outpatient Hospital Diabetic Education and Training Program Limited diabetic education and training services rendered through programs recognized by the American Diabetes Association, or provided by Certified Diabetes Educators are reimbursed at the lower of the provider's actual customary charge, or the allowable charge as established by the Department's fee schedule.

b. **Rural Health Clinics** - A Rural Health Clinic (RHC) is a facility located in a rural area designated as a shortage area, and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases.

i. Care and Services Provided – RHC services are defined as follows:

a. Physician services; or

b. Services and supplies incidental to physician services including drugs and biologicals which cannot be self administered; or

c. Physician assistant services; or

d. Nurse practitioner or clinical nurse specialist services; or

e. Clinical psychologist services; or

f. Clinical social worker services; or

g. Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would otherwise be covered if furnished by or incident to a physician service; or

h. In the case of a RHC that is located in an area that has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual.

ii. Encounter - An encounter is a face-to-face contact for the provision of a medical or mental service, between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse, clinic social worker, clinical psychologist, or other specialized nurse practitioner.

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2. b. ii. a. Contacts with more than one (1) discipline of health professional (medical, or mental,) in the same day and in the same location constitute a separate encounter (limited to two (2) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical, and mental conditions.

(1) A core service ordered by a health professional who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

(2) Multiple contacts with clinic staff of the same discipline (as defined in Attachment 4.19-B.c.i.a-h) on the same day related to the same illness or injury are considered a single encounter.

b. Services incidental to a billable encounter include in-house radiology, in-house laboratory services, injectable medications, medical equipment and supplies.

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c. ~~Any other medical service is excluded from the encounter rate calculations.~~

iii. Conditions of Participation - A qualified RHC applicant will be recognized as a Medicaid provider with the following stipulations:

a. The provider is confirmed as eligible by the Public Health Service and CMS on and after April 1, 1990; and

2. b. iii. b. Written agreements between the provider and subcontractors will state that the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify that failure to maintain such records voids the agreement between the subcontractor and the provider.

iv. **REIMBURSEMENT - GENERAL**

Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

a. All Rural Health Clinic services are reimbursed on a prospective payment system for services furnished on or after January 1, 2001 and each succeeding fiscal year.

b. An encounter rate will be established for medical/mental separately. These encounter rates will be set up prospectively using the center's reasonable medical/ mental costs determined by the audited cost report for fiscal years 1999 and 2000. The costs for each of these periods will be divided by the total number of encounters for each period to arrive at a cost per encounter. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the perspective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental rates for the period 1.1.2001 to 9.30.2001.

c. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The RHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the RHC scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

2. b. iv. d. A change in the scope of services is defined to include such things as ~~significant expansion or remodeling of an existing clinic,~~ addition of new service, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic that could significantly change a clinics total allowable cost per encounter. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

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e. Until the State transitions to the prospective payment system, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

f. For newly qualified RHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

g. In the case of any RHC that contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

h. The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be ~~treated as ambulatory services, and excluded from the encounter rate calculation.~~ included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

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2. c. **Federally Qualified Health Center** (FQHC) - Effective retroactively to April 1, 1990, federally qualified health centers are defined as community health centers, migrant health centers, providers of care for the homeless, outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act, as well as clinics that qualify but are not actually receiving grant funds under section 329, 330, or 340 of the Public Health Service Act may provide ambulatory services to Medical Assistance recipients.

i. Care and Services Provided - FQHC services are defined as follows:

a. Physician services; or

b. Services and supplies incidental to physician services including drugs and biologicals which cannot be self administered; or

c. Physician assistant services; or

d. Nurse practitioner or clinical nurse specialist services; or

e. Clinical psychologist services; or

f. Clinical social worker services; or

g. Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, dentist, or dental hygienist services as would otherwise be covered if furnished by or incident to a physician service; or

h. Dental services including both the licensed dentist and dental hygienist; or

i. In the case of an FQHC that is located in an area that has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual; and

2. c. i. j. Other Title XIX payable ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide; including pneumocccal or immunization vaccine and its administration.

ii. Encounter - An encounter is a face-to-face contact for the provision of medical, mental, or dental service between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse, clinic social worker, clinical psychologist, other specialized nurse practitioner, dentist or dental hygienist.

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a. Contacts with more than one (1) discipline of health professional (medical, mental, or dental) in the same day and in the same location constitute a separate encounter (limited to three (3) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical, mental, and dental health issues.

(1) A core service ordered by a health professional who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

(2) Multiple contacts with clinic staff of the same discipline (as defined in Attachment 4.19-B.c.i.a-j) on the same day related to the same illness or injury are considered a single encounter.

2. c. ii. b. Services incidental to a billable encounter include in-house radiology, physical therapy, occupational therapy, speech therapy, audiology services, in-house laboratory services, in-house nutritional education or dietary counseling and monitoring by a registered dietician, injectable medications, medical equipment and supplies.

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~~c. Any other medical service is excluded from the encounter rate calculations.~~

iii. Conditions of Participation - A qualified FQHC applicant will be recognized as a Medicaid provider with the following stipulations:

a. The provider is confirmed as eligible by the Public Health Service and CMS on and after April 1, 1990; and

b. The FQHC applicant will simultaneously terminate its Medicaid Rural Health Clinic and other Department specified Medicaid agreements from which the FQHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement.

c. Written agreements between the provider and subcontractors will state that the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify that failure to maintain such records voids the agreement between the subcontractor and the provider.

iv. **REIMBURSEMENT - GENERAL**

Payment for Federally Qualified Health Center services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

a. All Federally Qualified Health Center services are reimbursed on a prospective payment system for services furnished on or after January 1, 2001 and each succeeding fiscal year.

2. c. iv. b. An encounter rate will be established for medical/mental and dental encounters separately. These encounter rates will be set up prospectively using the center's reasonable medical/mental and dental costs determined by the audited cost report for fiscal years 1999 and 2000. The costs for each of these periods will be divided by the total number of encounters for each period to arrive at a cost per encounter. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the ~~perspective~~ prospective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental and dental rates for the period 1.1.2001 to 9.30.2001.

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c. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental and dental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The FQHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the FQHC's scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

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d. A change in the scope of services is defined to include such things as ~~significant expansion or remodeling of an existing clinic,~~ addition of new services, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic that could significantly change a clinics total allowable cost per encounter. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

e. Until the State transitions to the prospective payment system, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

2. c. iv. f. For newly qualified FQHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

g. In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

h. The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be ~~treated as ambulatory services, and excluded from the encounter rate calculation.~~ included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

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